

**BLAIR GASTROENTEROLOGY ASSOCIATES  
ALLEGHENY REGIONAL ENDOSCOPY**

**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**Uses and Disclosures**

There are a number of situations where we may use or disclose to other persons or entities your confidential medical information. Certain uses and disclosures will require you to sign an Acknowledgement that you received our Notice of Privacy Practices, including treatment, payment and health care operations. Any use or disclosure of your protected health information requires for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures required by law or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

**Use and Disclosure without Patient Acknowledgement of this Notice**

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes:

**Treatment.** Providers use and disclose PHI without specific consent to provide, coordinate and manage health care and related services. These activities include coordination or management of health care by Providers with other third parties; consultation among our Providers or between our Providers and other health care providers; and patient referrals among providers.

**Payment.** Providers, Employee Plans and Affiliated Health Plans all use and disclose PHI to obtain and provide reimbursement for the provision of health care to patients and health plan members. We also use and disclose PHI to obtain premiums or determine or fulfill our responsibilities for coverage and provision of benefits under the plans. Examples of these payment activities include: billing, claims management, collections activities, and administration of reinsurance, stop loss and excess loss insurance policies, as well as related data processing; making eligibility, coverage, medical necessity, and related determinations, coordinating benefits among various payors, recovering payments from third parties liable for coverage; risk adjustment; utilization review activities, and disclosures to consumer reporting agencies. We may use or disclose PHI in connection with payment activities with or without your consent.

**Health Care Operations.** Providers use and disclose PHI in connection with their standard business operations, including quality assessment and improvement activities. Examples of these activities include obtaining accreditation from independent organizations like the Accreditation

Association for Ambulatory Health Care, the Joint Commission for the Accreditation of Healthcare Organizations, the National Committee for Quality Assurance and others, outcomes evaluation and development of clinical guidelines, operation of preventive health, early detection and disease management programs, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives, and related functions; evaluations of health care providers (credentialing and peer review activities) and health plans; operation of educational programs; underwriting, premium rating and other activities relating to the creation, renewal or replacement of health benefits contracts; obtaining reinsurance, stop-loss and excess loss insurance; conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs; business planning and development; and business management and general administrative activities, including data and information systems management, customer service, resolution of internal grievances, and sales, mergers, transfers, or consolidations with other providers or health plans or prospective providers or health plans.

#### Use and Disclosure Without Acknowledgement or Authorization

There are certain circumstances under which we may use or disclose your medical information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law enforcement activities, judicial and administrative proceedings and in the event of death. Specifically, we are required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases and HIV/AIDS status. We are also required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law enforcement officials information that you or another person are in immediate threat of danger to your health or safety as a result of violent activity. We must also provide medical record information when ordered by a court of law to do so.

#### Authorization for Use or Disclosure

Except as outlined in the above sections, your medical information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental health treatment, drug and alcohol abuse, HIV/AIDS, or sexually transmitted diseases which may be contained in your medical records. We likewise will not disclose your medical record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

#### Additional Uses and Disclosures

Appointment Reminders and Treatment Alternatives. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits or services that may be of interest by phone and answering machine, at phone numbers that you provide us, or by mail.

**Marketing.** We must obtain your written authorization prior to using your PHI to send you any marketing materials. (We can however, provide you with marketing material in a face-to-face encounter, without obtaining Your Marketing Authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining Your Marketing Authorization.)

**Workers Compensation.** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

**Public Health and Safety.** We may use or disclose PHI as necessary to prevent or reduce a serious and imminent threat to the health or safety of a person or the public, to people who may be able to reduce the threat, including the threatened person or law enforcement officials; or for other public health activities to public health authorities (such as the Pennsylvania Department of Health or the U.S. Department of Health and Human Services) engaged in preventing or controlling disease, injury, or disability. For example, New York health care providers are required to report information about patients with certain conditions, such as HIV/AIDS and cancer, to central registries; they also are required to report information about immunizations administered to their patients. We also may disclose PHI to manufacturers of drugs, biologics, devices, and other products regulated by the federal Food and Drug Administration when the information is related to their quality, safety, or effectiveness. PHI also may be disclosed to certain people exposed to communicable diseases and to employers in connection with occupational health and safety or worker's compensation matters.

**Required by Law.** We may use or disclose PHI to the extent such use or disclosure is required by law and it complies with and is limited to the requirements of that law. For example, if you are treated by one of our Providers for a gunshot or knife wound or similar trauma, we may be required to report that information to the police. If we suspect a person is a victim of abuse, neglect, or domestic violence, we may be required to file a report to the authorities or another local or state agency and possibly to the police as well. We also use and disclose PHI for certain law enforcement purposes and in response to official subpoenas, court orders, discovery requests and other legal process. In addition, we use and disclose PHI in connection with health oversight activities (e.g., government audits of our compliance with certain laws and regulations; oversight of government-funded health benefits programs, etc.).

**Other Government Functions.** We may use or disclose PHI in connection with military and veterans activities, national security and intelligence activities, protective services for the President of the United States and other dignitaries, and certain correctional facility activities.

**Family and Friends.** Under certain circumstances, we may disclose PHI to family members, other relatives, or close personal friends or others that you identify to the extent it is directly relevant to their involvement with your care or payment related to your care; or to notify them of your location, general condition, or death.

**After Death.** We may disclose PHI to coroners or medical examiners to identify a person who has died, determine the cause of death, or perform other functions authorized by law; and (before or after death) to funeral homes as necessary to carry out their duties. In addition, PHI of a person

who has died may be used or disclosed in connection with research that does not involve any live subjects.

### **Individual Rights**

You have certain rights with respect to your medical record information, as follows:

1. You may request that we restrict the uses and disclosures of your medical records information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with respect to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.
2. You have the right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you will be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.
3. You have the right to inspect, copy and request amendment to your medical records. Access to your medical records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding or for which your access is otherwise restricted by law. We will charge a reasonable fee for providing a copy of your medical records, or a summary of those records, at your request, which includes the cost of copying, postage, or preparation of an explanation or summary of the information.
4. All requests for inspection, copying and/or amending information in your medical records must be made in writing and be addressed to "Privacy Officer" at our address. We will respond to your request in a timely fashion.
5. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your medical records information except for disclosures required for treatment, payment and health care operations, disclosures that require an Authorization, disclosures incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any 12-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same 12-month period.

6. You have the right to obtain a paper copy of this notice if the notice was initially provided to you electronically, and to take one home with you if you wish.
7. All requests related to your rights herein must be made in writing and addressed to "Privacy Officer" at the address noted below.

### **Our Duties**

We have the following duties with respect to the maintenance, use and disclosure of your medical records:

1. We are required by law to maintain the privacy of the protected health information in your medical records and to provide you with this Notice of its legal duties and privacy practices with respect to that information.
2. We are required to abide by the terms of this Notice currently in effect.
3. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and medical records we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

### **Complaints**

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights with respect to confidential information in your medical records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of a complaint to us) or to the person designated by the U.S. Department of Health and Human Services, if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint.

### **Contact Person**

All questions concerning this Notice or requests made pursuant to it should be addressed to:

Privacy Officer  
Blair Gastroenterology Associates  
810 Valley View Blvd.  
Altoona, PA 16602  
814-946-5469  
814-946-4970 Fax

### **Effective Date**

This Change in Notice is effective **December 15, 2015** and applies to all protected health information contained in your medical records maintained by us.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY  
PRACTICES FOR PROTECTED HEALTH INFORMATION**

I acknowledge that I have received **Blair Gastroenterology Associates/Allegheny Regional Endoscopy's** Notice of Privacy Practices for protected health information.

Date: \_\_\_\_\_ Name of Patient: \_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature of Patient/Personal Representative

**Documentation of Good Faith Effort to Obtain Written Acknowledgement**

I made a good faith effort to obtain the patient's written acknowledgement of our Notice of Privacy Practices for protected health information by (check all that apply):

- Showing the patient the Notice of Privacy Practices posted in our office.
- Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service.
- Giving the patient all necessary information to obtain our Notice of Privacy Practices on our website.
- Asking the patient to sign this Acknowledgement form.
- Other (explain in detail) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I was unable to obtain the patient's written Acknowledgement because (check all that apply):

- The patient refused to sign this form.
- The patient would not sign the form because the patient said he/she did not understand the Notice.
- Other (explain in detail) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Name: \_\_\_\_\_

**Notes:** This written Acknowledgement must be completed no later than the first date health care services or treatment is provided to the patient after April 14, 2003. This Acknowledgement must be retained in the patient's permanent records.